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Southern Nuclear Operating Company
the southern electric system

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Docket No.: 50-348

10 CFR 50.73

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

Joseph M. Farley Nuclear Plant - Unit 1
Licensee Event Report Number 96-005-00
Valve Misalignment Due To
Personnel Error Results in Missed Surveillance

Ladies and Gentlemen:

Joseph M. Farley Nuclear Plant Licensee Event Report No. 96-005-00 (Unit 1) is being submitted in accordance with 10 CFR 50.36(c)(2) and 50.73(a)(2)(i). If you have any questions, please advise.

Respectfully submitted,

DJ Morey

Dave Morey

EFB/clt:LER96-05.doc

Enclosure

cc: Mr. S. D. Ebneter, Region II Administrator
Mr. J. I. Zimmerman, NRR Project Manager
Mr. T. M. Ross, Plant Sr. Resident Inspector

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NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Joseph M. Farley Nuclear Plant - Unit 1	0 5 0 0 0 3 4 8	1 OF 4

TITLE (4)
Valve Misalignment Due to Personnel Error Results in Missed Surveillance

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME
0 8	2 7	9 6	9 6	- 0 0 5	- 0 0	0 9	2 0	9 6	FACILITY NAME

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

OPERATING MODE (9)						
1	20.2201(b)	20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
POWER LEVEL (10)	20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
1 0 0	20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
	20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
	20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below
	20.2203(a)(2)(iv)	50.36(c)(2)	X	50.73(a)(2)(vii)		or in NRC Form 366A

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
R.D. Hill, General Manager - Nuclear Plant	AREA CODE 3 3 4 8 9 9 - 5 1 5 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-space typewritten lines) (16)

At approximately 0805 on August 27, 1996, with Unit 1 in Mode 1 operating at 100 percent reactor power it was determined that Unit 1 had been operating in a condition prohibited by Technical Specifications (TS). TS 4.8.1.1.2.a.3 requires that each emergency diesel generator set be demonstrated operable by verifying the fuel transfer pump can transfer fuel from the storage system to the day tank. TS 3.8.1.1 requires that with one emergency diesel generator set inoperable, demonstrate the operability of the remaining A.C. sources and remaining emergency diesel generator set. However, it was determined the 1B diesel generator fuel transfer system (which consists of two transfer pumps in parallel) was not capable of adequately transferring fuel from the 1B diesel generator fuel oil storage tank to the 1B diesel generator day tank due to the misalignment of two valves. The improperly positioned valves had been open since approximately 1820 on August 23, 1996 and the remaining A.C. sources and emergency diesel generator set had not been demonstrated operable in accordance with TS 3.8.1.1. The valves were restored to the required position at the time of discovery.

The cause of this event was cognitive personnel error due to a system operator failing to ensure two valves were closed. The individual involved in this event has been disciplined.

Plant and System Identification

Westinghouse -- Pressurized Water Reactor
Energy Industry Identification System codes are identified in the text as [XX].

Description of Event

At approximately 0805 on August 27, 1996, with Unit 1 in Mode 1 operating at 100 percent reactor power it was determined that Unit 1 had been operating in a condition prohibited by Technical Specifications (TS). TS 4.8.1.1.2.a.3 requires that each emergency diesel generator[EK] set be demonstrated operable by verifying the fuel transfer pump can transfer fuel from the storage system to the day tank. TS 3.8.1.1 requires that with one emergency diesel generator set inoperable, demonstrate the operability of the remaining A.C. sources and remaining emergency diesel generator set. However, it was determined the 1B diesel generator fuel transfer system[DC] (which consists of two transfer pumps in parallel) was not capable of adequately transferring fuel from the 1B diesel generator fuel oil storage tank to the 1B diesel generator day tank due to the misalignment of two valves. TS 3.8.1.1 requires that with one emergency diesel generator set inoperable, demonstrate the operability of the remaining A.C. sources and remaining emergency diesel generator set. The improperly positioned valves had been open since approximately 1820 on August 23, 1996 and the remaining A.C. sources and emergency diesel generator set had not been demonstrated operable in accordance with TS 3.8.1.1. The valves were restored to the required position at the time of discovery.

The 1B diesel generator fuel oil transfer system was not capable of adequately transferring fuel from the 1B diesel generator fuel oil storage tank to the 1B diesel generator day tank due to the misalignment of two valves. The valves had not been realigned to the closed position following the transfer of fuel oil from the auxiliary fuel oil storage tank to the 1B diesel generator fuel oil storage tank on August 23, 1996. The system operator responsible for the positioning of the valves failed to utilize existing guidance and inappropriately concluded the two valves were located in the responsible area of another individual standing a separate on-duty position. Furthermore, he failed to ensure the valves were properly positioned by the other individual.

Although the misalignment of valves did not isolate the flowpath between the 1B diesel generator fuel oil storage tank and the 1B diesel generator day tank, the valve configuration created an additional flow path which would have resulted in negligible flow reaching the 1B diesel generator day tank upon demand. Even though an adequate fuel supply would not have been provided to the day tank as a result of the improperly opened valves, the design of the day tank alarm system

provides two alarms (low and low-low level) which would provide approximately 2 hours to investigate and correct the problem in the event of required diesel generator operation. Without any operator intervention the diesel generator would be expected to run at full load for approximately 4 hours.

All diesel generators were subsequently run satisfactorily and all A.C. sources were verified operable. Furthermore, during the event, all other diesel generators were operable.

Cause of Event

The cause of this event was cognitive personnel error due to a system operator failing to ensure the two valves were closed.

Safety Assessment

There was no other ESF equipment in the affected train made inoperable by this event. All ESF equipment in the redundant train remained operable during this event.

The health and safety of the public was not affected by this event.

Based on the above, no safety concerns exist.

Corrective Action

The individual involved in this event has been disciplined. A summary of this event, along with management expectations, will be provided to appropriate operations personnel. This will be completed by November 15, 1996.

Additional Information

The following recent LERs have been submitted due to personnel inappropriately concluding that tasks had been properly completed:

96-002-00 (Shared) - Technical Specification Surveillance Requirements Not Met and Common Cause Failure Identified

95-002-00 (Unit 1) - Missed Surveillance for Inoperable Axial Flux Difference Monitor Alarm